Patient Name: _____ Date of Birth: _____

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment.

This information serves as:

- A basis for planning your care and treatment
- A means to communicate with healthcare professionals who contribute to your care
- A source of information for applying your diagnosis and treatment information to your bill, for payment purposes

As part of your treatment, payment or healthcare operations, it has become necessary to disclose health information to other healthcare providers (referrals or consultations), laboratories, insurance companies for payment and/or individuals or agencies as permitted or required by law.

ACKNOWLEDGEMENT:

I have been provided with a copy and the opportunity to read the "Patient Health Information Privacy Practices" that provides me a more complete description of health information uses and disclosures. I understand that I have the following rights:

- The right to read the "Patient Health Information Privacy Practices" prior to signing this consent
- The right to request a copy of the "Patient Health Information Privacy Practices" for my own use
- The right to request restrictions as to how my health information may be used or disclosed to carryout treatment, payment or other healthcare options

CONSENT/RESTRICTIONS:

I request the following consent/restrictions to the use or disclose of my healthcare information:

NAME	RELATIONSHIP TO PATIENT	MAY OBTAIN	MAY NOT OBTAIN

I FULLY UNDERSTAND, ACKNOWLEDGE AND ACCEPT THIS CONSENT:

_____ _____ _____

Signature of patient or parent/guardian Printed Name Date

* If person other than patient is signing, are you the parent, legal guardian or custodian, have power of attorney for this patient, for treatment, payment or healthcare operations? _____ Yes _____ No

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FOR OFFICE USE ONLY

( ) Consent form reviewed by (employee) _____ on (date) _____

( ) Patient/parent/legal guardian/custodian/power of attorney refused to sign consent form

( ) Reason for refusal to sign

( ) Restrictions were added by the patient/parent/legal guardian/custodian/power of attorney (see above)